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No.

In the Supreme Court of the United States

MICHAEL O. LEAVITT, SECRETARY OF HEALTH & HUMAN SERVICES, PETITIONER

v.

BAYSTATE HEALTH SYSTEMS, D/B/A/ BAYSTATE MEDICAL CENTER, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

PAUL D. CLEMENT
Solicitor General
Counsel of Record

PETER D. KEISLER
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

LISA S. BLATT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
ANNE M. MURPHY
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

PAULA M. STANNARD
Acting General Counsel

THOMAS R. BARKER
Deputy General Counsel

KATHLEEN H. MCGUAN
Associate General Counsel

MARK D. POLSTON
Deputy Associate General Counsel for Litigation

GERARD KEATING
SYLVIA J. TRUJILLO
Attorneys
Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

Whether a federal court may, under 28 U.S.C. 1361, compel the Secretary of Health and Human Services to reopen and revise final Medicare payment determinations where the Secretary prospectively changed his interpretation of the Medicare Act to acquiesce in adverse circuit decisions and expressly ordered his fiscal intermediaries not to reopen and revise any final determinations.

PARTIES TO THE PROCEEDINGS

The petitioner in this Court is the Secretary of Health and Human Services, Michael O. Leavitt. The respondents are twenty-six Medicare providers: Baystate He..lth Systems d/b/a Baystate Medical Center, Berkshire Health Systems, Brockton Hospital, Carney Hospital, Cooley-Dickinson Hospital, Harrington Memorial Hospital, Holy Family Hospital, Holyoke Hospital, Jordan Hospital, Landmark Medical Center, Lawrence General Regional Health System, Inc., Lifespan, Lowell General Hospital, Memorial Hospital of Rhode Island, Morton Hospital and Medical Center, North Adams Regional Hospital, City of Quincy Hospital, Roger Williams Medical Center, Providence Health System, St. Anne's Hospital, Caritas Christi Health Care System, St. Joseph's Health Services of Rhode Island, Southcoast Hospitals Group, Sturdy Memorial Hospital, University of Massachusetts Memorial Medical Center, doing business as University of Massachusetts Memorial Hospital, and University of Massachusetts University Medical Center, doing business as University of Massachusetts University Hospital, which were appellees in the court of appeals.

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PETITION FOR A WRIT OF CERTIORARI

The Solicitor General, on behalf of the Secretary of Health and Human Services, Michael O. Leavitt, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-11a) is reported at 414 F.3d 7. The opinion of the district court (App., *infra*, 12a-30a) is reported at 309 F. Supp. 2d 89.

JURISDICTION

The judgment of the court of appeals was entered on July 1, 2005. A petition for rehearing was denied on September 28, 2005 (App., *infra*, 47a-48a). On December 19, 2005, Chief Justice Roberts extended the time within which to file a petition for a writ of certiorari to and including January 26, 2006. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

REGULATORY PROVISION INVOLVED

The reopening regulation, 42 C.F.R. 405.1885 (1997), and Ruling 97-2 are reproduced at App., *infra*, 49a-55a.

STATEMENT

1. a. Title XVIII of the Social Security Act establishes the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services. When patient beneficiaries receive covered services, the Secretary of Health and Human Services (HHS) reimburses the providers of those services under the Medicare Act and the implementing regulations. 42 U.S.C. 1395d, 1395ww(d).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b)(1), 413.24(f). The cost report is filed with a "fiscal intermediary," generally a private insurance company that acts as the Secretary's agent and determines the amount of payments to be made pursuant to an agreement with the Secretary. 42 U.S.C. 1395h. The intermediary analyzes the cost report, audits it to the extent necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount due the provider for Medicare services during the reporting period. *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 525 U.S. 449, 451 (1999) (*Your Home*); 42 C.F.R. 405.1803.

Congress specified in the Medicare Act a comprehensive scheme for administrative and judicial review of a fiscal intermediary's final determination. A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB) in HHS if the amount in controversy is at least $10,000 (or $50,000 for group appeals) and the provider requests a hearing within 180 days after notice

of the intermediary's final determination. 42 U.S.C. 1395*oo*(a)(1)(A)(i), (a)(2), (a)(3), (b), and (h); 42 C.F.R. 405.1835, 405.1845(a). See *Your Home*, 525 U.S. at 451; *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 403-404 (1988). The Board's decision is subject to review by the Secretary and to judicial review in federal district court if an action is brought within 60 days. 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1875 and 405.1877; *Your Home*, 525 U.S. at 451.

b. The Secretary has promulgated regulations governing "[r]eopening" of Medicare reimbursement determinations and decisions. 42 C.F.R. 405.1885; *Your Home*, 525 U.S. at 451. The regulations provide that a determination by the intermediary or a decision of the PRRB or the Secretary on administrative appeal may be reopened within three years with respect to specific "findings on matters at issue in such determination or decision," on the motion of either the affected provider or the relevant decision-maker—the intermediary, PRRB or Secretary. 42 C.F.R. 405.1885(a); see *Your Home*, 535 U.S. at 451. For the time period relevant to this case, the regulations further provided that "[a] determination * * * rendered by the intermediary shall be reopened and revised by the intermediary" if, "within the aforementioned 3-year period," the Health Care Financing Administration (HCFA) in HHS notifies the intermediary that such determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA] in accordance with the Secretary's agreement with the intermediary." 42 C.F.R. 405.1885(b) (1997).[1]

The Secretary's reopening regulations also provide that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R.

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[1] HCFA has been renamed the Centers for Medicare and Medicaid Services (CMS). 66 Fed. Reg. 35,437 (2001).

405.1885(c). This Court held in *Your Home* that an intermediary's denial of a request under 42 C.F.R. 405.1885(a) (1997) to reopen an intermediary's final determination was not subject to review by the PRRB or by a federal court under federal question jurisdiction, 28 U.S.C. 1331, or the mandamus statute, 28 U.S.C. 1361. 525 U.S. at 452-457.

2. In February 1997, HCFA issued Ruling 97-2, which prospectively acquiesced on a nationwide basis in the adverse decisions of four courts of appeals that had rejected the Secretary's method for calculating the "disproportionate share hospital" (DSH) adjustment to the rates applicable to those hospitals that serve a disproportionate percentage of low-income patients. App., *infra*, 49a-53a. In authorizing DSH adjustments, the Medicare Act requires calculation of a fraction whose numerator is "the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance" under Medicaid. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). In a preamble to the 1986 regulations implementing the DSH provision, the Secretary explained that he interpreted the Act to mean that "Medicaid covered days will include only those days for which benefits are payable," 51 Fed. Reg. 16,777 (1986); accord 51 Fed. Reg. 31,460 (1986), and thus to exclude days for which patients were not eligible under the terms of a State's Medicaid plan to receive payment for services.

Ruling 97-2 explained that, although HCFA "believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language," HCFA recognized that its interpretation "is contrary to the applicable law in four judicial circuits." App., *infra*, 51a. Accordingly, HCFA announced that it would follow the adverse appellate decisions on a nationwide basis beginning on or after February 27, 1997, in order "to ensure national uniformity in calculation of DSH adjustments." *Ibid.* Ruling 97-2 stated that HCFA would begin to "count in the Medicaid fraction